

**TESTIMONY**

**Of**

**Robert S. Galvin, MD**

**before**

**THE SUBCOMMITTEE ON PERSONNEL**

**of**

**THE ARMED SERVICES COMMITTEE**

**of the**

**UNITED STATES SENATE**

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## **TESTIMONY: SENATE ARMED FORCES SUBCOMMITTEE ON PERSONNEL**

Senator Graham, Senator Nelson, and distinguished Subcommittee members, I appreciate the opportunity to share with you today how leading employers in the private sector are addressing the problem of rising health care costs. My name is Robert Galvin, and my title is Director, Global Health, for General Electric. In this position I am responsible for the design, operations and financial performance of the health benefits GE offers its employees, family members, and retirees as well as for the overall health of this population. Our population totals about a million people with an annual expenditure exceeding two billion dollars.

The challenges that the Military Health System and a company like General Electric face in addressing health care costs are actually quite similar, outside of the direct care you provide. We both have highly trained workforces and keeping them healthy is critical for the optimal functioning of the operation; also, despite our relative sizes, rising health care costs represent significant pressure on our budgets; and third, both of us face the daunting challenge of trying to restrain excessive health care costs while not alienating our workforces or delivering them a less-than-outstanding health benefit in the process.

Let me say at the outset that we have not found a “silver bullet” to solve these challenges. What we have found is that a combination of flawless execution of purchasing basics plus a willingness to be innovative, using purchasing clout to address fundamental problems in our health care system, yield the optimal results. Probably our most important learning is that because tough decisions are often necessary, and health care is always ‘personal’, a sense of trust

between those making decisions on benefits and those who use the benefits is critically important. We have learned that constant, candid communication is the key---and that when we believe we have communicated enough, we are probably only half the way there.

In my testimony today, I will focus on issues pertaining to the actual management of costs from the point of view of the purchaser. Other panel members will focus on the broader policy issues and trends facing the US health care system or the actual details of the Military Health System.

Health care costs are rising rapidly today for many reasons. Employers find it useful to distinguish between those causes over which we have little control, e.g. increased costs due to advances in technology and an ageing population, and those over which we believe sound management practices can have an influence. Two areas have the biggest impact.

- (1) **Benefit Design**
- (2) **Using Procurement to Address Waste in the Health Care System**

Although several other areas are important, e.g. population health, financial controllership, etc., due to my limited time today, my focus will be on the two aforementioned topics.

## **BENEFIT DESIGN**

Designing the health benefit is a very important function. At GE, our philosophy is to (1) protect people from the financial consequences of catastrophic illness; (2) offer coverage for medical services that are evidence-based, including preventive services, and to (3) maintain a reasonable level of cost sharing. We monitor our design in two ways: we perform annual satisfaction surveys to make sure we are meeting the needs of our employees; and we use an outside benefits consulting firm to benchmark the value of our design. Because we operate in very competitive markets, we need to offer a rich enough package to attract and retain employees but not so rich that we put ourselves at a competitive disadvantage with respect to our cost base.

An unintended consequence of having too rich a benefit package is that beneficiaries will drop other coverage available to them and preferentially choose the richest plan. Several large employers have now added a substantial fee for employees who could get other coverage, e.g. through a spouse, but choose to go with the richer plan offered by the large employer. The richness of your Tricare for Life plan, though designed with the best intentions, could suffer from this unintended consequence.

Cost sharing is a key feature of health benefit design. Benchmarking data show that for most large employers, the desired split between company and employee payment is 70%/30%. This means that, overall, the company pays for 70% of the bill and the employee pays the other 30%. Having a reasonable amount of cost sharing is critical because there is well-accepted evidence that the demand for health services is elastic: very low payments by consumers lead to

predictable increases in the amount of services used. On the other hand, higher payments lead to the use of fewer services, and some of the avoided services may have been necessary ones. It is not in anyone's best interest for these services to be reduced. Finding the right amount of overall cost sharing is an ongoing challenge.

It is worth noting that those employers who have a very low level of cost sharing are the ones facing the greatest problems with health care increases.

Although increases in cost sharing are never enthusiastically received, most companies devote significant resources to educate employees about rising health care costs and to explain why a reasonable amount of cost sharing is, indeed, reasonable. These companies have found that with the right explanations, their workforces are willing to accept reasonable changes.

## **ADDRESSING WASTE IN THE HEALTH CARE SYSTEM**

A series of startling findings about the quality and efficiency of the health care system have emerged over the past 5 years. Experts from the Institute of Medicine and Rand have discovered that:

- **Overall, adults receive only about 55% of recommended care**
- **Unnecessary procedures and services accounts for over 30% of health spending**
- **There is wide variation on performance between doctors and hospitals**

The quality shortfalls have real consequences: the IOM found that up to 100,000 preventable deaths occur in our hospitals annually. Looking at just the waste, what this means to a company

like GE is that several hundred million dollars may be spent on unnecessary services. So even with a state-of-the-art benefit design, we are still spending a lot of money unnecessarily. If you apply the same percentage to the annual spend of the MHS, you will get a very high number.

Why is there such waste and variation in quality in our health system, long lauded as “the best in the world”? A series of papers published by the Institute of Medicine over the past decade concludes that there are multiple reasons for our system performance. For purposes of today’s testimony, let me focus on one of these: the fact that those who purchase health care have not demanded more and have not held the system accountable for what it delivers.

The IOM recommended that purchasers of health care use their buying clout to drive changes in two areas: first, **transparency**, i.e. pushing for the public release of performance measurement of doctors and hospitals, and second, **payment reform**. One of the significant changes over the past decade is that metrics have been developed that can measure quality at the level of doctors and hospitals. While it is true that these measures are still being perfected, most private sector employers believe that they are accurate enough for public release. Although there is little scientific data to cite, it is common sense in the business world that what is measured is managed, and that making public the performance of doctors and hospitals will spur improvement. Health services experts have continuously demonstrated that there are significant differences between doctors and hospitals in how well and how efficiently they deliver medical care. Our analysis shows that in every major market that GE has employees the same level of quality is available at prices that differ by 30-40%. Our data shows that only 35% of our hospital admissions occur at hospitals that score highest on both cost and efficiency. When we ask our

employees, over 80% say they want this kind of information and will use it to make decisions about who to see and where to go for treatment.

Our payment system to doctors and hospitals is such that reimbursement is divorced from performance. In Medicare hospitals that perform superbly at a specific procedure are paid identically to those with much lower performance. The same is true for doctors. Again, although there is no clear scientific proof that paying for performance will increase quality and efficiency, it is a cardinal rule of procurement that you get what you pay for. Several large employers have developed a program called **Bridges-to-Excellence**, which rewards physicians who demonstrate the highest quality. Although researchers are currently evaluating this program, actuarial models predict substantial savings for employers and significant bonuses for high-performing physicians.

GE believes that there are substantial savings available from making performance available to the public and changing the payment system. The Pacific Business Group on Health, a private sector purchasing coalition based in California and representing 3 million covered lives, reported on research findings which showed that up to 17% of premium could be saved if employees and family members chose to see those providers with the best performance scores. Actuarial modeling in the Medicare program, and presented in testimony at recent hearings at the Way and Means Sub-Committee on Health, suggests that with relatively little movement of patients to high-scoring doctors and hospitals, savings of 3-4% in the Medicare program are possible. These themes of transparency and pay-for-performance are strongly supported by Mark McClellan, CMS Administrator, as well as by Med PAC.

How would health care purchasers go about catalyzing this kind of change? The answer: through the procurement process. Several years ago, a number of private and public sector purchasers formed the **Leapfrog Group**, now 150 members strong, to bring about this kind of change in health care purchasing. The Leapfrog Group's strategy is for each of its members to insist on transparency and pay-for-performance in its contracts with health plans. If enough purchasers include this language in their contracts, health plans will then change their contracts with doctors and hospitals, insisting on data release and paying for performance. Though the Department of Defense has been an ex-officio Board member of Leapfrog, Tricare has not included the aforementioned language in its health plan contracts.

The findings on waste and variations in quality refer to the private sector health care system. The Military Health System has its own doctors and hospitals, and I am not aware of data related to their performance. However, I am aware of the performance data from the Veterans Hospital Administration health system, which has transformed itself over the past ten years into a system that produces the highest quality of any system in the United States. The VHA outperforms the private sector delivery system consistently by 15-20% on quality measures and probably by that much on efficiency. In the absence of the kind of culture change and investment in information technology that the VHA has undergone, it is unlikely that the MHS delivery system performs as well. However, to the extent that the MHS commits itself to VHA-level improvement, or that



military personnel use the VHA health system, it is likely that substantial savings, and improvements in quality, are possible.

## **SUMMARY**

In summary, the issue of health care costs is of great importance to private sector employers. The Human Resource Policy Association, the trade association representing the Senior Human Resource professionals for the largest 200 companies, has made healthy care its number one priority. This Association is promoting the practices I have outlined in my testimony today.

The Military Health System and GE face many similar challenges. Although state-of-the-art benefit design, aggressive procurement and working with the delivery system to improve value has not solved the health care cost problem, it has certainly made health care more affordable and arguably has helped improve care. Given Tricare's size, if it were to adopt the Leapfrog health plan language and implement the Bridges-to-Excellence program, I believe that the DOD could not only impact its own health costs, but contribute substantially to the improvement of the entire US health care system.

Thank you for asking me to be with you here today.